



## **Texas Department of Insurance**

### **Division of Workers' Comp**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

DR AHMED KHALIFA  
1415 HIGHWAY 6 SOUTH SUITE 400D  
SUGARLAND TX 77478

#### **Respondent Name**

AMERICAN ZURICH INSURANCE COMPANY

#### **Carrier's Austin Representative Box**

Box Number 19

#### **MFDR Tracking Number**

M4-12-0196-01

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Fee Guideline"

**Amount in Dispute:** \$159.43

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** The respondent did not submit a response to this dispute.

**Response Submitted by:** N/A

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 2, 2011	99214	\$159.43	\$ 159.43

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.203 set out the fee guideline s for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
3. Explanation of Benefits (EOB's) were not submitted for review in this dispute.

## Issues

1. Is the requestor entitled to reimbursement for the disputed services?

## Findings

1. Per 28 Texas Administrative Code, Section §134.203(b) and (c), for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply...Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules. To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications; for service categories of Evaluation Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting." The 2011 Division conversion factor to be applied is \$54.54. The MAR for CPT code 99214 is as follows: DWC conversion factor of \$54.54 divided by Medicare conversion factor of 33.9764 = \$1.605 X Participating amount of \$99.32 = \$159.43. This amount is recommended for reimbursement.

## Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$159.43.

## **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$159.43 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

## Authorized Signature

_____	_____	October 17, 2011
Signature	Medical Fee Dispute Resolution Officer	Date

## **YOUR RIGHT TO REQUEST AN APPEAL**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**